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ABSTRACT

This study was undertaken by several clinicians to obtain ratings of symptomatology and coping behavior of mental patients from different ethnic groups in Hawaii. Three dimensions of depression were studied: physical agitation, verbal retention, and optimism. The aims of the study were to describe the symptomatic and coping behaviors which are more apparent to members of one ethnic group than to another. A rating instrument; the Ching-Katz-Sanborn Scale (CKS), designed to measure differences in emotionally expressive behavior among Caucasians, Pilipinos, Hawaiians, and Japanese subjects was used. Sixteen subjects, two men and two women, from each ethnic group were videotaped and rated by objective raters from each respective ethnic group. Each tape was viewed and rated by at least 3 men and 3 women from each ethnic group. The clinician's observation of symptomatic and coping behaviors of the subjects indicated that Caucasians saw more tension/anxiety and verbal retention, Filipinos saw more bizarreness and hostility. Hawaiians saw more positive attributes, and the Japanese did not have a characteristic bias. A conclusion of the study is that "if part of each illness is in the eye of a beholder, then we may have to treat the beholder as well as the patient to effect a cure." (Author/JP)

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PERCEPTION OF SYMPTOMATOLOGY IN ETHNIC GROUPS

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While objectivity in the diagnosis of mental illness is a valued goal in the training of clinicians; lay community members, who are the first to respond to symptoms of mental illness in a family member, seldom have the benefit of objective study in forming their initial impressions of the illness. They react to the patient on the basis of how he has deviated from the norms of their society, particularly the norms for symptomatic and coping behavior. They also react in terms of the thresholds for perception of symptomatology common in their cultural group.

A number of studies (Cooper, et. al., 1967; Sandifer, et. al., 1967; Katz, et. al., 1972) have pointed to the existence of bias or different thresholds for the perception of symptomatology on the part of clinicians from differing cultural backgrounds. Studies dealing with symptom bias in the general population, particularly in regard to the perceptual thresholds of persons from differing cultural backgrounds, are fewer in number.

When we look at the process of how one forms an impression of another person there is substantial evidence to indicate that implicit personality theories exist in the perceiver.

Several studies concerning the stereotypes that French and English-Canadians have for each other found two components existing in trait attribution; a reaction shared by members of one community about certain attributes of members of the other plus a variety of individual reactions

to the other group (Gardner, 1973; Gardner, Taylor, and Feenstra, 1970; Gardner and Taylor, 1969). As only two groups were included in these studies, the community reaction of one group was considered to be a stereotype of the other group. If more than two community groups had been studied, one could have seen whether or not the perceptual bias of one group generalized across groups.

There is some evidence that the perceptions of clinicians differ from the perceptions of relatives rating the same patients. Katz, et. al. (1967) found that Hawaii-Caucasian patients were seen as significantly less obstreperous and expansive in the community by relatives and significantly more so in the hospital by Caucasian clinicians when compared to Hawaii-Japanese patients.

Draguns (1972) has suggested that techniques need to be developed that allow for the comparison of patient and normal behavior as seen by both lay persons and clinicians. This suggestion entails the development of norms for both the perception of behavior and the expression of behavior.

Previous studies in Hawaii have led to the development of norms for symptom behavior in the community against which patient behavior can be compared. The method, however, does not allow for separating the perception from the expression of the symptoms.

An earlier study (Sanborn and Katz, 1972) led us to suspect that members of ethnic groups have blind spots to some forms of symptom expression. Japanese nurses did not see hostility in a videotape of a manic patient while Caucasian nurses did. Caucasian nurses did not see hostility in a videotaped depressed patient while Japanese nurses did. The accuracy question was not addressed, i.e., whether or not the hosti-

lity was in the nurse viewer or in the videotaped patient.

Answers to the question of whether or not there are specific blind spots existing in each ethnic group will come from studies where a number of groups view standard tapes so that there may be some consensual validation of what characteristics are represented on the tapes. In addition a number of tapes representative of each cultural group are required to insure that attributes representative of cultural groups rather than of individuals are measured.

The present study was undertaken to obtain ratings of symptomatology and coping behavior of and by several ethnic groups in Hawaii. The study aims were to describe the symptomatic and coping behaviors which are more apparent to members of one ethnic group than to those of another.

The measuring instrument utilized in the study was the Ching-Katz-Sanborn Scale (CKS), a rating instrument designed to measure differences in emotionally expressive behavior among ethnic groups. The scale uses sixty-six items to describe ordinary social behavior that can be observed in a videotaped standard interview. The CKS provides 34 items descriptive of symptom behavior and 32 items descriptive of coping behavior. The items have previously been combined into sixteen clusters by principle component factor analysis using a varimax rotation with eigen values greater than one.

Four major ethnic groups in Hawaii were studied: Japanese, Caucasian, Filipino, and Hawaiian. The method provided sixteen videotaped subjects: two men and two women from each ethnic group. Each tape was viewed and rated by at least three men and three women from each ethnic group.

There were 96 raters for the 384 ratings required by the design. Actually 217 raters participated.

The videotape recorded a ten minute standard interview based on the Spitzer Mental Status Schedule ( ). Both viewers and taped subjects were community college students.

Figure 1 depicts the results for each ethnic group of 24 raters looking at videotapes from all four ethnic groups.

We find that each ethnic group sees more of certain symptom clusters than do the others.

The Caucasians see more tension/anxiety and verbal retention, Filipinos see more bizarreness and hostility. Hawaiians see more positive attributes. The Japanese do not appear to have a characteristic bias. Their ratings more closely match measures of central tendency for the total group.

Let us look at some of the clusters in more depth. Physical agitation and verbal retentiveness are both related to descriptions of depression. Optimism is one of the positive factors that relates to depression.

Table 2

	Japanese	Caucasian	Filipino	Hawaiian	
Physical agitation	- 4*	+ 2	+ 8	- 2	Raters
	- 4	+ 40	- 38	0	Tapes
Verbal retention	+ 2	+ 18	- 5	- 17	Raters
	+ 11	- 25	- 5	- 10	Tapes
Optimism	- 4	- 20	- 22	+ 4	Raters
	0	- 40	+ 20	+ 20	Tapes

*Zero is the mean for all groups on the factor.

There is no significant difference in the way members of the four ethnic groups rate physical agitation. They agree that the Caucasians show much of this symptom and the Filipinos show little. Our conclusion would be, that since there is consensus on this cluster that what is perceived is the actual behavior and not a stereotype. Stereotypes would appear as interactions between rater groups and tape groups.

For perceiving the symptom verbal retentiveness, the Caucasians have a significantly lower threshold, while the Hawaiians have a higher threshold. The Japanese are rated as expressing higher levels of retentiveness while the Caucasians are perceived as having low levels of the symptom. The finding relates to earlier studies where relatives of Caucasian patients were more alert to retentive behavior than were clinicians.

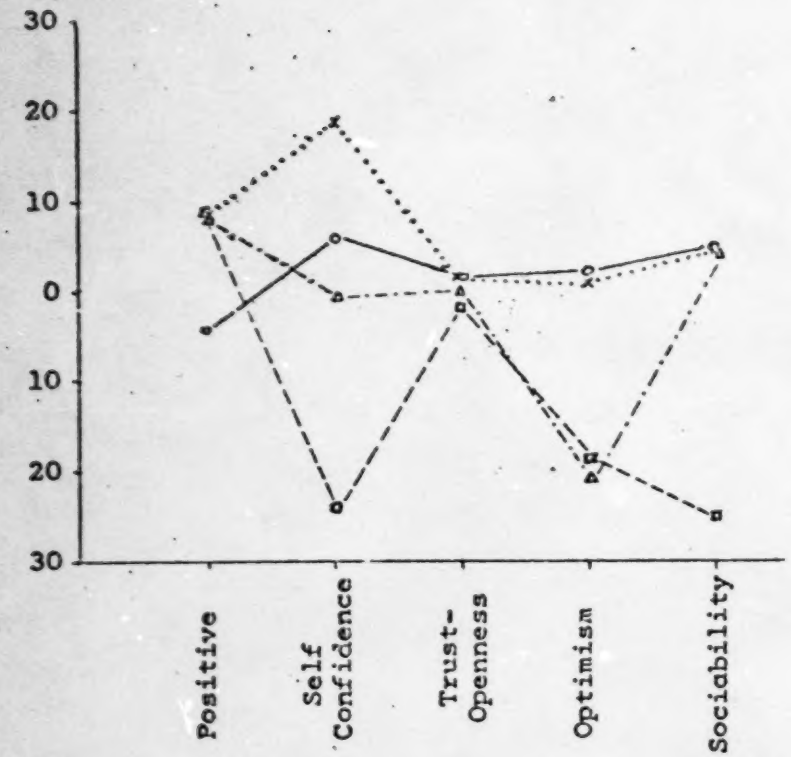
Finally, the coping factor called optimism is rated differentially, with Caucasians and Filipinos having higher thresholds than Japanese or Hawaiians. For expression of optimism, the Caucasians are rated low while the Filipinos and Hawaiians are rated high.

While it is difficult to keep in mind sixteen factors varying in expression and perception in four groups, the level of significance of the results encourages us that the method has the sensitivity to provide for the description of normal and patient behavior by both community members and clinicians. Availability of the method makes possible the following applications.

1. Measures of symptomatic and coping behavior that are comparable across culturally different groups.
2. Training programs that can give clinicians the tools to overcome their own bias while recognizing the bias of others.
3. Directing treatment to the problems as seen by community

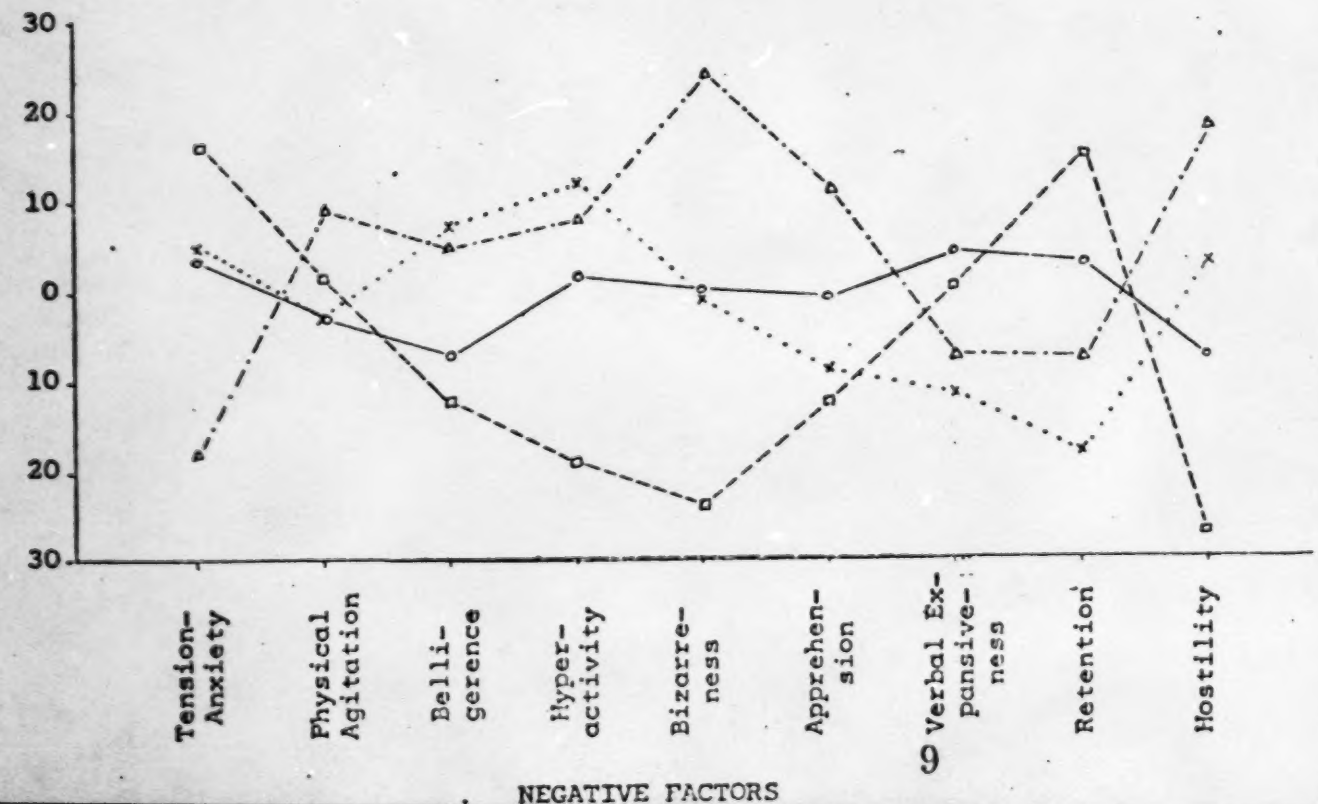
members.

If part of each illness is in the eye of a beholder, then we may have to treat the beholder as well as the patient to effect a cure.



RATERS CHART

Cross Perception Study



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